AMENDED IN SENATE JUNE 4, 2007

AMENDED IN SENATE MAY 1, 2007

AMENDED IN SENATE APRIL 11, 2007

SENATE BILL No. 350

Introduced by Senator Runner

February 20, 2007

An act to amend Sections 127400, 127405, 127425, ~~and 127430~~ *127430, 127440, and 127444* of the Health and Safety Code, relating to hospitals.

LEGISLATIVE COUNSEL'S DIGEST

SB 350, as amended, Runner. Hospitals: discount payment and charity care policies.

Existing law requires each hospital, as a condition of licensure, to maintain a written policy regarding discount payments for financially qualified patients as well as a written charity care policy.

Existing law defines "high medical costs" for the purposes of determining patient eligibility to include, in part, annual out-of-pocket expenses that exceed 10% of the family's income in the prior 12 months.

This bill would specify that the out-of-pocket expenses are for health care services, including medications that exceed 10% of the family's income in the prior 12 months.

Existing law requires any extended payment plans offered by a hospital to be interest free.

This bill would limit that requirement to situations where all the payments are timely made and would ~~prohibit reporting adverse information to a consumer credit reporting agency or commencement of civil action within an unspecified number of days of the first default,~~

~~as defined and would make conforming changes~~ *specify that the hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period, as provided. The bill would also prescribe procedures per the extension or renegotiation of an extended payment plan, and would prohibit the hospital, collection agency, or assignee from reporting adverse information to a consumer credit reporting agency or commencing a civil action against the patient for nonpayment prior to the time the extended payment plan is declared to be nonoperative. The bill would make related conforming changes.*

Existing law requires a hospital to reimburse the patient or patients any amount actually paid in excess of the amount due for hospital care, including interest.

This bill would prescribe the amount of interest required to be paid by the hospital for those excess amounts actually paid by a patient or patients, as well as the interest accrual date.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 127400 of the Health and Safety Code is amended to read:

127400. As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f) or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Hospital" means any facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of Mental Health or the Department of Corrections.

(e) "Office" means the Office of Statewide Health Planning and Development.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

(g) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (c), if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses for health care services, including medications that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital's charity care policy.

(h) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner*, as defined in Section 297 of the Family Code*, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

SEC. 2. Section 127405 of the Health and Safety Code is amended to read:

127405. (a) (1) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level, as defined in subdivision (c) of Section 127400, shall be eligible to apply for participation under each hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this act, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 350 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.

(2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity.

(b) Each hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient may negotiate the terms of the payment plan.

(c) The charity care policy shall clearly state eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.

(d) Each hospital shall limit expected payment for services it provides to any patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 124700, eligible under its discount payment policy to the amount of payment the hospital would receive for providing services from Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

(e) Any patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination.

(1) For the purpose of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

(2) For the purpose of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. A hospital may require waivers or releases from the patient or the patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value. Information ~~obtained by the hospital pursuant to this paragraph from the patient consisting of tax returns, paystubs, and information on monetary assets of the patient or the patient's family for the purposes of determining eligibility,~~ *obtained pursuant to this paragraph* shall not be used for collections activities. *Nothing in this paragraph prohibits the use of information obtained by a collector*

independently of the eligibility process for charity care or discounted care.

~~(3) Eligibility for charity care or discounted payments under this section may be determined by the hospital when it is in receipt of a timely application and any information provided by the patient as specified in paragraph (1) or paragraph (2), respectively.~~

(3) Eligibility for discounted payments or charity care may be determined at any time the hospital is in receipt of information specified in paragraph (1) or paragraph (2), respectively.

SEC. 3. Section 127425 of the Health and Safety Code is amended to read:

127425. (a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by Section 127405.

(c) At time of billing, each hospital shall provide a written summary consistent with Section 127410, which includes the same information concerning services and charges provided to all other patients who receive care at the hospital.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, as defined in this article, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the hospital's charity care ~~of~~ *or* discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

(f) (1) The hospital or other assignee which is an affiliate or subsidiary of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

(2) A collection agency or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills, any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration ~~file~~ *filed* by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure or was the patient's homestead at the time of the death of a person other than the patient *who* is asserting the protections of this paragraph.

(3) This requirement does not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any

enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free if all payments are timely made under the terms of the extended payment plan. ~~Upon the occurrence of the first default by a patient under the terms of a hospital's extended payment plan, the hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment during the ____ day period from the date of the first default, in order to allow the patient to cure the defaults or attempt to renegotiate the terms of the hospital extended payment plan.~~ *The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. The hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.*

~~For purposes of this subdivision, "default" shall mean the failure to meet one or more payments that are required by the patient's payment plan.~~

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. This subdivision does not limit or alter the obligation of the patient to make payments from the

first date due on the obligation owing to the hospital ~~and to pay the interest on the obligation, except as set forth in subdivision (g), pursuant to any contract or applicable statute.~~ *pursuant to any contract or applicable statute in the event that the patient fails to make all consecutive payments due during a 90-day period under an extended or renegotiated hospital extended payment plan.*

SEC. 4. Section 127430 of the Health and Safety Code is amended to read:

127430. (a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:

(1) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it ~~is in the form as the notice set forth in Section 1812.700 of the Civil Code, or if it~~ appears in substantially the following form: "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."

(2) A statement that nonprofit credit counseling services may be available in the area.

(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.

(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

SEC. 5. Section 127440 of the Health and Safety Code is amended to read:

127440. The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. *Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.*

SEC. 6. Section 127444 of the Health and Safety Code is amended to read:

127444. Nothing in this article shall be construed to prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates, nor shall this article preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits. *No health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for hospital services because a hospital has waived, or will waive, collection of all or a portion of a patient's bill for hospital services in accordance with the hospital's charity care or discount payment policy, notwithstanding any contractual provision.*

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